STATE OF ARIZONA

DEPARTMENT OF INSURANCE

JANE DEE HULL
Governor

2910 NORTH 44th STREET, SUITE 210
PHOENIX, ARIZONA 85018-7256
602/912-8456 (phone) 602/912-8452 (fax)
www.state.az.us/id

CHARLES R. COHEN
Director of Insurance

CIRCULAR LETTER 2000-6

To: Insurance Agents and Brokers, Insurance Industry Representatives, Insurance Trade Associations, Life & Disability Insurers, Property & Casualty Insurers, And Other Interested Parties

From: Charles R. Cohen
Director of Insurance

Date: May 17, 2000

Re: **2000 Arizona Insurance Laws**

This Circular Letter summarizes the major pieces of newly enacted legislation that affect the Department and its licensees and consumers. This summary is not meant as an exhaustive list or a detailed legal analysis of all bills that bear on insurance. It describes the main areas of substantive change, but does not capture all details or necessarily cover all bills that may be of relevance to a particular reader. Do not regard this summary as a legal opinion or a binding interpretation of the legislation. All interested persons are encouraged to obtain copies of the enacted bills by contacting the Arizona Secretary of State's Office at (602) 542-4086 or from the Arizona legislative web site at the following internet address: http://www.azleg.state.az.us. Any questions regarding this circular letter should be directed to Vista Thompson Brown, Executive Assistant for Policy Affairs, 602/912-8456.

Sine die for the 2000 Arizona Forty-fourth Legislature, Second Regular Session was April 18, 2000. Except as otherwise noted below, all insurance related legislation has a general effective date of July 18, 2000.

The following bills were bills initiated by the Department and are described first: HB 2016, HB 2017, HB 2021, SB 1032, SB 1069, and SB 1070.

DEPARTMENT BILLS

HB 2016. Department of insurance: licensing; enforcement (Ch. 319)

- Amends A.R.S. § 20-162 regarding the right to stay a Director's order. Brings the statute into conformity with general administrative law in A.R.S. § 41-1092.11. A party cannot obtain an automatic stay of an order if the Director makes an express finding that summary action is essential for protection of public health, safety, and welfare. Also requires a prompt hearing on the order.

- Enacts A.R.S. § 20-284.01 by adding a definition of "member." When used in reference to a firm or corporation applying for, or possessing a license as an agent or broker, "member" means an owner with more than a 10% share of the voting rights.

- Amends A.R.S. §§ 20-290, 20-291, and 20-316 to allow the Department to take licensing action (denial, suspension, revocation) against a corporate agent/broker, based on the background or conduct of the corporation's principals (e.g. members and officers). Also permits the Department to obtain background information on the principals.

- Enacts A.R.S. § 20-305 to allow the Department to issue an administrative cease and desist order against a party engaged in unauthorized activity as a producer. (Makes conforming language changes to A.R.S. § 20-401.02 regarding such orders issued against an unauthorized insurer.)

- Amends A.R.S. §§ 20-315 and 20-316.01 to allow the Department to accept the voluntary surrender of a producer license; prohibits the producer from reapplying for the same license for 6 months; and requires resolution of any disciplinary proceedings before acceptance of the voluntary surrender.

- Amends A.R.S. § 20-411 and enacts A.R.S. § 20-411.01 to allow for licensure of non-resident surplus lines brokers, and to establish a residency requirement for resident surplus lines brokers. Also permits a person licensed as a surplus lines broker in a state other than Arizona to pay surplus lines tax due in Arizona (relative to certain kinds of surplus lines transactions) without being subject to penalties for the unlicensed transaction of surplus lines insurance. *(The Department will be issuing a more detailed circular letter on this topic.)*

- Enacts A.R.S. § 20-489 to require the Department to enforce the Violent Crime Control Act, a federal law prohibiting anyone with a prior felony conviction involving dishonesty or breach of trust, from working in the business of insurance without permission of a state insurance director, and prohibits insurers from employing such persons. Also gives the Department related rulemaking authority.

HB 2017. Workers' compensation insurance; rating organizations (Ch. 199)

The Department initiated this bill in response to the state's 1999 experience with multiple workers' compensation ("WC") rating organizations . The bill was the product of a workgroup composed of Department staff and interested stakeholders.

- Enacts A.R.S. § 20-343, a definitional section, with the following terms:
  "Board" (the Workers' Compensation Appeals Board; see A.R.S. § 20-367)
  "Classification plan"
  "Designated rating organization" (see A.R.S. § 20-371(F))
  "Designated statistical agent" (see A.R.S. § 20-371(D))
  "Experience rating plan"
  "Schedule rating plan"
  "Statistical plan"
  "Uniform plan"
  "Uniform rate filing"
  "Workers' compensation rates"

- Enacts A.R.S. § 20-344 which requires rating organizations (RO) and insurers to adhere to the uniform statistical plan, the uniform classification plan, and the uniform experience rating plan, if the Director has elected to designate such plans. Allows an RO to use its own statistical plan, to the extent it does not conflict with any designated uniform plan. An insurer, (either on its own, or through its RO,) may develop subclassifications to the uniform classification plan. Subclassifications cannot conflict with the uniform classification plan, and must be on file with the Director at least 15 days before they can become effective. The Director may disapprove subclassifications that conflict. If the Director does not designate any uniform plans, insurers must follow the rating plans of their RO.

- Amends A.R.S. § 20-357 to specify that WC insurers must make required filings through membership in one RO, which is not required to be the designated RO. An RO must annually file rates to be effective October 1st.

- Amends A.R.S. § 20-359 to specify that insurers must adhere to the filings of the insurer's RO, except allows insurers to file: (1) uniform percentage variations to the statewide rate portion of the rate filing; and (2) subclassification rules deviating from the RO's rule filing. Deviations must be filed at least 15 days in advance. The Director may authorize early use of the deviation. Specifies circumstances and timing of expiration of the deviation (automatic expiration at midnight, on September 30th, for RO rates filed the prior October), and requirement to file deviation with RO.

- Repeals A.R.S. § 20-360 regarding equitable apportionment of assigned risks. *(All assigned risks are now governed by A.R.S. § 23-1091, discussed below.)*

- Amends A.R.S. § 20-361 regarding licensure of RO to require applicant RO to file a certified financial statement and a plan for data transfer if the RO ceases business in Arizona. Also provides for license to remain effective indefinitely (rather than automatic expiration after 3 years) unless suspended or revoked, or the Director accepts surrender of the license.

- Amends A.R.S. § 20-363 by requiring an RO to admit any WC insurer as a member of the RO, and eliminating the concept of subscribership to an RO. Allows RO members to ask the Director to review the RO's rules and regulations.

- Repeals A.R.S. § 20-367 regarding the provision of information concerning rates and challenges to the application of a rating system to a particular insured.

- Enacts A.R.S. § 20-367 establishing a Workers' Compensation Appeals Board ("Board") in the Department to address challenges to the application of a rating system (as specified in A.R.S. § 20-367.01). Specifies the composition of the voting and advisory members, who are not entitled to compensation.

- Enacts A.R.S. § 20-367.01 requiring ROs and insurers to make rate information available to insureds upon payment of a reasonable fee. Specifies the procedure for an insured to appeal to the Board to review the application of a rating system to the insured. Requires the RO whose system is subject to an appeal to attend any Board hearing and provide information on the application of the rating system. Sets 30-day time limit for Board decisions and allows dissatisfied party to appeal the Board's decision to the Director. Provides for payment of costs.

- Amends A.R.S. § 20-371 to specify that an insured is not required to report loss experience on a basis that is inconsistent with any designated uniform classification plan. Specifies that the Director can designate an organization, other than an active WC insurer, to act as the Director's statistical agent to compile WC data and perform other related services.

- Enacts A.R.S. § 20-371(E) requiring insurers to report their loss and expense experience to their RO, and requiring an RO to report that experience to the designated statistical agent ("DSA") (if the Director has chosen to designate a statistical agent). If the RO cannot report to the DSA, its member insurers must directly report their experience to the DSA.

- Enacts A.R.S. § 20-371(F) requiring the Director to designate an RO to annually make and file statewide WC rates, but only if Arizona has more than one active RO.

- Enacts A.R.S. § 20-371(G) requiring the designated RO to annually file rates no later than August 1st, for rates to become effective October 1st. The Director may disapprove rates that do not comply with A.R.S. § 20-356(1). Further requires insurers to adhere to the uniform rate filing by the designated RO, except for deviations otherwise permitted under A.R.S. § 20-359(A).

- Enacts A.R.S. § 20-371(H) allowing the DSA and designated RO to charge reasonable fees for their services. Licensed ROs pay fees on a ratable basis.

- Enacts A.R.S. § 20-371(J) and (K), which respectively require: (1) the Director to adopt the statistical, classification, and experience rating plans of the designated RO as the uniform plans - if the state has more than 1 active rating organization; and (2) insurers to follow the plans of their member RO if the Director fails to designate uniform plans.

- Amends A.R.S. § 20-2102(22) to clarify the definition of "residual market mechanism" as an agreement, among insurers, for the equitable apportionment of applicants who are unable to buy insurance through ordinary methods.

- Amends A.R.S. § 23-1091 regarding the WC assigned risk plan. Provides for only 1 assigned risk plan, and requires the Director to procure a qualified administrator for that plan. The administrator may charge WC insurers a reasonable administration fee, with insurers to pay fees on a proportional basis. Requires the administrator to have a plan of operation, which the Director may require the administrator to amend. The plan must provide for selection of one or more WC insurers as servicing carriers. The administrator may be a servicing carrier. The administrator must measure a servicing carrier's performance against established standards. Specifies the duties of a servicing carrier (provision of coverage and safety management services, payment of claims, performance of other related duties.) The plan must also specify a method for apportioning WC assigned risks. Unless the Director chooses another method, the rates for the assigned risk plan will be the rates filed by any designated RO, plus a uniform percentage increase. Rating classifications must conform to the uniform plan; subclasses and deviations are not allowed.

- Makes conforming and grammatical changes throughout all statutes included in the bill.

HB 2021. Insurers: financial requirements; procedures (Ch. 134)

A.R.S. § 20-223 currently requires insurers to file their statements of financial condition in accordance with the *Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners* ("NAIC") ("*the Manual*"). The NAIC has adopted a new accounting manual containing standardized statements of statutory accounting principles. Insurers must conform to *the Manual* for financial filings with an "as of" date on and after January 1, 2001. *(See Department Circular Letter 1999-8.)* This bill amends certain Arizona statutes that are not consistent with the standardized accounting principles, to make them consistent with *the Manual*. Specifically:

- Amends A.R.S. § 20-501 regarding eligible assets:
    - Limits asset regarding interest accrued on a mortgage loan by reducing accrual period from 18 months to 180 days.
    - Eliminates prohibition on counting life insurance premiums in the course of collection; such premiums that are not less than 3 months past due (less payable commissions) can be counted as an asset.
    - Eliminates prohibition on counting life insurance installment premiums; such premiums can be counted as allowed in *the Manual*.
    - Eliminates general provision allowing assets listed on the NAIC annual statement form to be counted as assets.
    - Adds deferred tax assets as allowed in *the Manual*.
    - Adds electronic data processing equipment, net of accumulated depreciation, with the depreciation period limited to a period of not more than 3 years. The admitted value shall be consistent with *the Manual*.
    - Adds goodwill, as allowed in *the Manual*.

- Amends A.R.S. § 20-503 regarding assets not allowed as deductions from liabilities by striking "goodwill, trade names, and other like intangible assets" from the list of excluded assets.

- Amends A.R.S. § 20-506 regarding unearned premium reserve by requiring reserves to be computed in accordance with *the Manual*, and striking the computation table in the statute.

- Amends A.R.S. § 20-509 by requiring an insurer to establish a premium deficiency reserve if the insurer's anticipated losses, expenses, commissions, and other costs, exceed the recorded unearned premium reserve, plus future installment premiums. The insurer must establish the deficiency reserve by recording an additional liability according to *the Manual*.

- Enacts A.R.S. § 20-512.01 providing for valuation of joint ventures, partnerships and limited liability companies based on underlying equity, as reported in the entity's financial statements, and as specified in *the Manual*.

- Amends A.R.S. § 20-532 regarding eligible investments to specify that investment limitations must be based on the last December 31st financial statement unless *the Manual* specifies use of a more current statement.

- Amends A.R.S. §§ 20-553 and 20-557 regarding mortgages to allow an insurer to invest in construction loans according to *the Manual*, if the real property is improved or will be improved with the loan proceeds. Defines construction loan as a mortgage for less than a 3-year term, made to finance construction of an improvement, and secured by the underlying real property. Limits reported asset to 80% of the property's fair market value, as determined by an appraisal, which may consider the planned improvements, as well as the status of completion of the improvements. Prohibits an insurer from investing more than 2% of its assets in construction loans.

- Repeals A.R.S. § 20-560 regarding electronic and data processing equipment. (*These assets are now covered under A.R.S. § 20-501.*)

- Amends A.R.S. § 20-561 regarding collateral loans to give insurers broader authority to lend funds in negotiable promissory notes, other than real property, if the loans otherwise qualify under Title 20, Chapter 3, Article 2. Lists other sections applicable to loans secured by real estate.

- Amends A.R.S. § 20-725 regarding borrowed surplus, and specifies the Director's authority to prior approve repayment of principal and payment of interest. While principal and interest remain unpaid, the insurer's financial statements must show the unpaid amounts, as set forth in *the Manual*. If the Director has approved payment of interest, the interest is treated as a liability. The promissory note securing the loan must provide: (1) that the holder's interest is subordinate to claims of policyholders, claimants, beneficiaries, and other creditor classes (other than surplus note holders); and (2) that payment of interest or principle requires the Director's prior approval.

- Enacts A.R.S. § 20-1059.01. Insurance entities that directly provide health care services to enrollees are allowed certain other admitted assets, beyond those listed in A.R.S. § 20-501, if the assets are used for direct delivery of services, specifically: (1) furnishings, medical equipment, and improvements, and (2) drugs and durable medical equipment and surgical supplies.

- Amends A.R.S. § 20-1083 to specify that unaffiliated credit life and disability reinsurers must submit an annual financial statement in a form acceptable to the Director, and are not automatically required to report on the financial "Blank" of the National Association of Insurance Commissioners.

- Amends A.R.S. § 20-1554 to require mortgage guaranty insurers to compute and maintain unearned premium reserves as specified in *the Manual*.

- Enacts A.R.S. § 20-1556.01 requiring a mortgage guaranty insurer to establish a premium deficiency reserve (through recording an additional liability as prescribed in the Manual) if the company's anticipated losses, expenses, and other costs exceed recorded unearned premium and contingency reserves, plus estimated renewal premiums on current policies.

- Amends A.R.S. § 20-1561 to clarify that A.R.S. § 20-223 (requiring financial reporting in accordance with *the Manual*) applies to title insurers.

- Amends A.R.S. § 20-1564 governing investments of title insurers. Changes value of investment in a title insurance plant from fair market value to actual cost, and limits aggregate admitted value to the amount allowed in *the Manual*.

- Amends A.R.S. § 20-1569 regarding the amount of a title insurer's unearned premium reserve to require compliance with the Manual.

- Amends A.R.S. § 20-1572 regarding a title insurer's reserve for unpaid losses and loss expense to also require a supplemental reserve, consisting of all other reserves needed to cover the insurer's liabilities for all losses, claims, and loss adjustment expenses.

- Makes conforming, technical, and grammatical changes throughout all statutes included in the bill, including: A.R.S. §§ 20-955, 20-991, and 20-1094.01.

This bill has a delayed effective date and applies to financial reporting for periods beginning on or after January 1, 2001.

SB 1032. Health insurance; portability; accountability; disclosure (Ch. 38)

The bill improves conformity between Arizona law and the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). It also amends the notice requirements for HIPAA eligibles to improve their awareness of their HIPAA rights, and the time frames for exercising those rights.

- Amends A.R.S. §§ 20-1379 and 20-2310 to affirm the obligation of the Department of Insurance to enforce HIPAA's requirements related to certificates of creditable coverage, including any federal regulations enacted to implement HIPAA, and to monitor insurers' compliance.

- Amends A.R.S. §§ 20-1379 and 20-2310 by requiring that a certificate of creditable coverage include the Department's consumer assistance number and specific language related to HIPAA rights, and the time frame for exercising those rights.

- Amends A.R.S. §§ 20-1379 and 20-2310 by adding a new subsections incorporating a federal requirement that an insurer must advise a prospective insured who has submitted a certificate of creditable coverage whether the insurer intends to impose any exclusion period for preexisting conditions, the amount of creditable coverage allowed towards the period, the basis for the insurer's determination, and an explanation of the right to challenge the determination, and the procedures for doing so.

- Amends A.R.S. § 20-1379 by adding a new paragraph (T)(1) which incorporates the definition of "affiliation period" from A.R.S. § 20-2301.

- Amends A.R.S. § 20-1380 to eliminate a duplicative notice requirement.

- Amends A.R.S. § 20-2304 to eliminate a provision that: (1) restricted small employers in an accountable health plan, from eligibility for coverage under A.R.S. § 36-2912 (Health Care Group operated by the Arizona Health Care Cost Containment System); and (2) restricted small employers covered under Health Care Group, from coverage under the accountable health plan law (A.R.S. § 20-2304).

- Repeals A.R.S. § 20-2306 establishing the health benefits plan committee, and makes conforming language changes in A.R.S. §§ 20-2301(A)(4), 20-2318, and 20-2345.

- Repeals A.R.S. § 20-2308(A) governing portability of health insurance coverage because of conflicts with HIPAA's provisions.

- Amends A.R.S. § 20-2309 to eliminate "repeated misuse of a provider network plan" as an allowable reason for non-renewal of a policy issued by an accountable health plan.

- Amends A.R.S. § 20-2310 to specify that a health benefits plan cannot include an affiliation period unless it complies with 45 CFR 146.119(b).

- Amends various statutes to substitute appropriate terminology such as "certificate of creditable coverage" for "prescribed certification" and to substitute "benefits" for "benefit," where appropriate. (A.R.S. §§ 20-1379, 20-2310, and 20-2345.)

SB 1069. Industrial insureds (Ch. 137)

In Laws 1998, Ch. 45 (SB 1136), property and casualty (P&C) insurance sold to industrial insureds was exempted from rate and form filing requirements, adding Arizona to the list of states permitting some deregulation of commercial insurance. The 1998 bill was silent on whether certain other laws governing P&C insurance should apply to industrial insureds. This bill addresses the applicability of other laws and clarifies requirements regarding insurance sold to industrial insureds pursuant to A.R.S. § 20-400.10 ("deregulated insurance transactions").

- Amends A.R.S. § 20-357 to clarify that workers' compensation insurance remains subject to rate and form filing requirements, and cannot be the subject of a deregulated insurance transaction.

- Amends A.R.S. § 20-382 to specifically provide that Title 20, Chapter 2, Article 4.1 does not apply to deregulated insurance transactions.

- Amends A.R.S. § 20-384 to prohibit an insurer from basing rates that are required to be filed under Article 4.1, on experience and losses incurred on deregulated insurance transactions. Thus, rating organizations (RO) and insurers must not comingle experience statistics maintained to support required rate filings with any statistical information maintained on deregulated business.

- Amends A.R.S. § 20-385 to clarify filing requirements for insurers that adopt prospective loss costs filed on the insurers' behalf by an RO. Insurers that do not adopt or that delay adoption of their RO's filed loss costs must provide the Director with acceptable notice of that decision within 30 days after the effective date. *(This statutory change is consistent with Department circular letter 1999-6.)*

- Enacts A.R.S. § 20-385(F) allowing the Director to issue an order exempting any rate, rating class, rating rule, rating program, or other rating type from the rate filing requirements of A.R.S. § 20-385 if the Director finds that filing is not needed to protect the public.

- Amends A.R.S. § 20-400.10 to specify that Chapter 2, Article 4.1 and numerous other insurance statutes do not apply to deregulated products. (The list of exclusions includes most requirements related to filed rates and forms; certain provisions of the unfair practices and frauds article; the article on guaranty fund coverage; and articles governing property insurance and cancellation/ nonrenewal of commercial insurance. (See A.R.S. § 20-400.10(D) for the complete list of exclusions.)

- Amends A.R.S. § 20-400.10 by enacting new subsections governing deregulated insurance.

    - At policy inception and renewal, an insured that purchases a deregulated product must annually certify, on a Department form, that the insured qualifies as an industrial insured as defined in A.R.S. § 20-401.07. The insurer must keep the certification in the insurer's file. *(The required form is attached to this circular and is also available on the Department's web site, under "Forms".)*

- The policy for a deregulated product must have a conspicuous warning statement that the Department has neither reviewed nor approved the policy and rates, and that insureds and claimants under the policy are ineligible for guaranty fund protection.
- Insurers must annually report on sales of deregulated products, including: number of policies, total premiums written and earned, total losses paid and incurred, and total incurred claims.

- Amends A.R.S. § 20-401.07 to revise and clarify the criteria for qualification as an industrial insured.

  - Clarifies that the premium threshold of $500,000 is based on gross premiums on property and casualty risks other than workers' compensation, for the insured's prior fiscal year.
  - Clarifies that the thresholds of $50 million in net worth and annual revenues of $100 million are measured as of the insured's prior fiscal year end, and must be verified by a certified public accountant.
  - Clarifies that the threshold of 500 employees per company or 1,000 employees per holding company system means full-time employees or equivalents.
  - Revises the threshold regarding use of a risk manager by specifying that the risk manager must provide skilled services in loss prevention, loss reduction, risk analysis, and insurance purchase, and must have one of the qualifications listed in the statute (BA or above in risk management, CPCU, CIC, ARM, CRM, or FRM) or otherwise approved by the Director.

- Amends A.R.S. § 20-407 to permit automatic surplus lines export for insurance sold to a qualified industrial insured. At policy inception and renewal, an insured that purchases surplus lines insurance under this exception must annually certify, on a Department form, that the insured qualifies as an industrial insured as defined in A.R.S. § 20-401.07. The surplus lines broker must maintain the certification. Such insurance is subject to all laws governing surplus lines insurance.

- Amends A.R.S. § 20-443 to allow the insurer to disclose that deregulated insurance does not have guaranty fund coverage.

- Amends A.R.S. § 20-680 to specify that deregulated insurance is not subject to Title 20, chapter 3, article 6 providing guaranty fund coverage.

SB 1070. Insurers: risk based capital requirements (Ch. 279)

This bill is based on a 1998 National Association of Insurance Commissioners' ("NAIC") model law establishing risk based capital ("RBC") requirements for managed care organizations. Under current law, most insurance companies must already comply with the RBC requirements set forth in A.R.S. § 20-488 through 20-488.11. This bill extends those requirements to managed care entities listed below under the newly defined term, "health organization."

- Amends A.R.S. § 20-488 by consolidating the Article's existing definitions into this definitions section, and repealing those definitions from other sections (A.R.S. §§ 20-488.02(F), 20-488.03(D), 20-488.04(B), 20-488.05(C).)

- Amends A.R.S. § 20-488 by adding a definition of "health organization" which means the following managed care entities: health care services organizations (established under A.R.S. § 20-1051 *et seq.*); service corporations (established under A.R.S. § 20-821 *et seq.*); and prepaid dental plan organizations (established under A.R.S. § 20-1001 *et seq.*). Also amends the definitions of domestic insurer and foreign insurer to include health organizations.

- Amends A.R.S. § 20-488.01 by requiring that a health organization's RBC be determined according to the formula in the RBC instructions adopted by the NAIC. The formula must account and adjust for asset risk, credit risk, underwriting risk, business risk, and all other relevant risks.

- Through the amended definition of insurer, subjects health organizations to the provisions of A.R.S. § 20-488.02 (company action level event); A.R.S. § 20-488.03 (regulatory action level event); A.R.S. § 20-488.04 (authorized control level event); and A.R.S. § 20-488.05 (mandatory control level event). These sections allow the Department to take appropriate remedial action when a health organization's capital falls below levels which vary with the degree of the organization's risk. The degree of Department action and intervention increases in relationship to the inadequacy of the organization's capital.

- Amends A.R.S. § 20-488.06 which governs an insurer's right to seek a hearing to challenge Department action under the RBC Article. Specifies that Department action or decisions on RBC issues constitute an appealable agency action under A.R.S. § 41-1092, and that any hearing is closed to public unless the principle party requests that it be open, pursuant to A.R.S. § 20-164(A).

- Amends A.R.S. § 20-488.08 to give the Director the authority to exempt a health organization from RBC requirements if: (1) the organization writes direct business only in Arizona; (2) no more than 5% of the organization's gross direct written premiums are attributable to reinsurance assumed from foreign insurers; and (3) the organization's direct annual premiums for comprehensive medical business do not exceed $2 million or the organization is a dental service corporation, optometric service corporation or prepaid dental plan covering less than 2,000 lives.

- Makes conforming changes to A.R.S. §§ 20-821(service corporations); 20-1006.01 and 20-1009 (prepaid dental plans); and 20-1052 and 20-1068 (health care services organizations).

The bill has a delayed effective date and applies to financial reporting for periods beginning on or after January 1, 2001.

ALL OTHER BILLS

SB 1076. Emergency; definition (Ch. 74)

- Amends A.R.S. § 20-2801 by adding a definition of "emergency ambulance services." The elements of the definition are:
  - Ambulance services.
  - Rendered by a licensed ambulance service.
  - After "the onset of a medical condition" manifested by symptoms of "pain, illness or injury."
  - The condition could reasonably be expected to result in:
    -serious jeopardy to the health of a person or unborn child;
    -serious impairment of bodily functions; or
    -serious dysfunction of bodily organs or parts.
  - Unless the person calls 911, gets an ambulance, and receives "time sensitive medical attention."

- Amends A.R.S. § 20-2803 to require health insurers to cover emergency ambulance services without prior authorization, subject to applicable co-pays, co-insurance, and deductibles.

SB 1082. Fire fighter cancer insurance program (Ch. 39)

- Amends A.R.S. § 38-642 regarding the firefighter cancer insurance program to allow the Public Safety personnel Retirement System manager to obtain insurance coverage for cancer through self-insurance. Current law requires the fund manager to contract for a group cancer insurance policy.

SB 1093. Department of Insurance; continuation (Ch. 306)

- Extends the Department of Insurance for 10 years.

SB 1096. Public agency insurance pools (Ch. 165)

- Amends A.R.S. §§ 11-952.01 and 41-621.01 governing public agency risk pools to provide that A.R.S. § 10-11301 (which prohibits distributions by non-profit corporations, other than distributions allowed under A.R.S. § 10-11302) does not apply to non-profit corporations formed under these two sections. Also extends the right to establish a pool under A.R.S. § 41-621.01 to subcontractors and allows establishment of a pool when contractors and subcontractors are working for a political subdivision, as well as the state.

SB 1099. Securities; conformity; revision (viatical settlements) (Ch. 108)

This bill contains many changes in the securities laws. This circular letter discusses only those changes related to viatical and life settlement contracts.

- Amends A.R.S. § 44-1801 to add a definition of "viatical or life settlement contract," which is defined as an "agreement for consideration" to acquire by any means any portion of the death benefit or ownership of a life insurance policy. The definition specifically excludes:
  - Any agreement for the original issuance of a policy,
  - Assignments to financial institutions as collateral for a loan,
  - Exercise of accelerated benefits under the policy,
  - Conveyances (by any means) from or between the original owner and a person holding an insurable interest under A.R.S. § 20-1104, or from such persons to a dealer or a person in the business of such purchases.

- Amends A.R.S. § 44-1801(26), the definition of "security," to include viatical or life settlement investment contracts, thereby subjecting such contracts to the full range of laws governing transactions in securities.

- Enacts A.R.S. § 44-1850 establishing a regulatory scheme administered by the Securities Division of the Arizona Corporation Commission ("Commission") for sales of viatical or life settlement contracts.

  - Subsection (A) provides that A.R.S. §§ 44-1841 and 44-1842 (which make sale and transaction of unregistered securities, unlawful) do not apply to viatical and life settlement contracts if:
    - The person conveying the interest does not enter into more than 3 such contracts per year; or
    - At least 10 days before the initial sale of such contract in or from Arizona, an issuer files certain documentation with the Commission:
      -Notice of intent to sell securities under this section.
      -The issuer's state of organization, and principal business and mailing addresses.
      -Expected date to begin sales.
      -A statement that the issuer is not prohibited from claiming an exemption.
      -Consent to service of process.
      -Audit report by an independent CPA, and specified financial information.
    - The issuer makes certain written disclosures to the offeree (buyer of the securities):
      -Right to rescind or cancel and get a refund.
      -Identifying information on the insurer issuing the underlying life policy.
      -Total value of the policy and the percentage the investor will own.
      -Descriptive information on the underlying life policy, and certain of its terms and conditions (e.g. group/individual, contestability; premiums).
      -Information on who will pay premiums and the amounts.
      -Information on sales fees and administrative costs.

  - Subsection (B) requires an issuer to file all sales and advertising materials with the Commission at least 10 days before use in Arizona.

- Subsection (C) allows an investor to rescind or cancel the sale for up to 7 days after payment of consideration or receipt of the required disclosures, whichever is later. The action must be in writing and transmitted to the issuer, who has 7 days from receipt of the notice to refund the investor's money.

- Subsection (D) allows the Commission to revoke a subsection (A) exemption if:
  -An issuer makes statements that are incomplete, inaccurate, or misleading.
  -The sale would operate as a fraud or deceit on investors.
  -The issuer is insolvent or in an unsound financial condition.
  -The issuer has refused the commission's request to examine information.
  -The issuer fails to reasonably supervise its salespersons, or retained a salesperson after receiving notice that the salesperson has committed a securities law violation.

- Subsection (E) prohibits an issuer from having an exemption if the issuer or related entities or principles:
  -Have certain criminal convictions involving racketeering, fraud, dishonesty, or other securities violations or are subject to court orders regarding the same offenses or consumer fraud.
  -Are under orders (within the past 10 years) restraining them from selling or buying securities.
  -Are subject to federal securities reporting laws, but is not in compliance
  -Are subject to an administrative or other regulatory order taking disciplinary action (denial, suspension, revocation) against a membership or license to act as a broker, dealer, salesperson, investment adviser or representative.

- Subsection (F) gives the Commission some discretionary authority to waive disqualifications under subsection (E).

- Subsection (G) qualifies a provision of subsection (E), by providing that it may be grounds for denial or revocation under subsection (D), under certain specified circumstances.

- Subsection (H) provides that attempted compliance with the requirements of this section (A.R.S. § 44-1850) is not an exclusive election.

SB 1130. Motor vehicle insurance; subrogation; non-renewal (Ch. 338)

- Amends A.R.S. § 12-555 to enact a two-year statute of limitations on claims for subrogation and reimbursement under A.R.S. § 20-259.01. The limitations period runs from the date of the insurer's first payment to their insured claimant under an uninsured motorist policy.

- Amends A.R.S. § 20-1631 to clarify that an insurer may non-renew a driver who has had at least 3 at-fault accidents in a 36-month period under any motor vehicle insurance policy with the insurer. (This change will allow an insurer to non-renew the "bad" driver even if the driver's accidents occurred in vehicles covered by different policies with that insurer, such as when an insurer covers multiple household vehicles under separate policies.)

SB 1172. Prepaid dental plan organizations (Ch. 339)

- Amends A.R.S. §§ 20-1003, 20-1004, 20-1008, 20-1009, 20-1014, 20-1015 to transfer, from Department of Health Services (DHS), to Department of Insurance, full responsibility for regulatory oversight of prepaid dental plan organizations. Under the transfer, the Insurance Department will:
    - At the time of initial application for a certificate of authority, approve the organization, its plans, facilities, and personnel, and its geographic service area.
    - Determine the basic dental services that an organization must provide; and
    - Determine whether the organization is an appropriate mechanism to achieve an effective prepaid dental plan based on rules issued by the Director, and whether the organization can provide basic dental services appropriate to the plan.

  The amendments will also:
    - Allow the Insurance Director to request that DHS or another person participate in an examination of an organization, and eliminates the DHS Director's right to examine the organization under A.R.S. § 20-1014.
    - Eliminate the requirement that an organization send a copy of its annual report to the DHS Director.

- Amends A.R.S. § 20-1019 regarding coordination of benefits between prepaid dental plans and indemnity insurers providing dental coverage. Although the indemnity insurer must pay benefits regardless of the prepaid dental plan, the indemnity insurer is not required to pay for "basic dental services," which are defined as services:
    - "Performed by a primary care dentist"
    - "Specifically defined as office visit fees, periodic diagnostic clinical oral examinations, radiographs, pulp vitality tests, prophylaxes or amalgam filings" and
    - "Covered under the prepaid dental plan."

- Transfers $133,000 from DHS to the Insurance Department in fiscal year 2001-2002 for 2 FTEs.

This bill has a delayed effective date of July 1, 2001.

SB 1173. Insurance discrimination; domestic violence (Ch. 370)

- Amends the definition of "domestic violence" in A.R.S. § 13-3601, a criminal code section, and enacts a conforming change in A.R.S. § 20-448(L)(3) regarding unfair discrimination in insurance. Domestic violence is defined to mean certain listed crimes when:
    - The victim and defendant:
        -Are currently or were previously married or living together;
        -Have a child or pregnancy in common; or
        -Are related, by blood or marriage, to the degree listed in the statute; or
    - The victim is a child now living with, or previously living with, the defendant, and is related by blood to the defendant's current or former spouse or cohabitant.

- Amends A.R.S. § 20-448(C) regarding unfair discrimination in insurance. Subsection (C) currently prohibits discrimination in insurance other than life and disability. It also has an express provision making the subsection inapplicable to premiums charged under chapter 2, article 4 (workers' compensation.) The bill strikes the express prohibition regarding workers' compensation.

- Amends A.R.S. § 20-448(G) regarding claims handling and coverage practices. Current law prohibits different treatment of domestic violence victims in life and disability insurance. The amendment extends the prohibition to property and casualty insurance, and to insureds that render services to victims of domestic violence (e.g. shelters and counselors.)

- Amends A.R.S. § 20-448(H) by adding a new paragraph that expressly permits a property or liability insurer to underwrite coverage based on an insured's claims history and the characteristics of the insured's property, using rating criteria consistent with the criteria listed in A.R.S. § 20-384.

- Enacts A.R.S. § 20-448(J) affirming that a property or liability insurer may exclude coverage for losses caused by an insured's intentional or fraudulent act. Prohibits an insurer from denying coverage when the property loss was caused by one insured's act of domestic violence towards a second insured, if the second insured who claims the loss: (1) cooperates in the loss investigation; and (2) did not cooperate in or contribute to causing the loss. An insurer may apply reasonable standards of proof for claims submitted, and may limit payment to the [victim] claimant's insurable interest in the property, minus any payment to a lender or person holding a secured interest in the property, and in accordance with coverage limit amounts. An insurer may subrogate against persons other than the victim.

- Enacts A.R.S. § 20-448(K) requiring insurers to adopt written policies and procedures for the insurer's employees, contractors, and producers to ensure that a victim's privacy and safety are protected in all actions involving the victim and the victim's policies and claims (e.g. applications, investigations, subrogation). The insurer must distribute the policies and procedures to persons having access to personal or privileged information regarding domestic violence.

SB 1213. Health insurance; cancer clinical trials (Ch. 371)

- Parallel enactments in: A.R.S. § 20-826.01 (service corporations); 20-934.01 (benefit insurers); 20-1057.01 (HMOs); 20-1342.03 (disability insurers); 20-1402.01 (group disability insurers); 20-1404.01 (blanket disability insurers); and 20-2326 (accountable health plans.)

- Requires health insurers to pay covered patient costs directly associated with an insured's voluntary participation in a cancer clinical trial at an Arizona institution. "Covered patient costs" mean those benefits the insurer would otherwise cover under the policy if the insured was receiving standard care. Health insurers are not responsible for clinical trial costs normally borne by government or the industry developing the treatment, such as the cost of the experimental drug or device, research management, and non-health services. "Cancer clinical trial" means a course of treatment that meets all the detailed, specific criteria outlined in the bill.

- The treatment must be:
  - Designed for treatment, palliation, or prevention of human cancer;
  - Conducted at an Arizona institution;
  - Provided as part of a study being conducted in a Phase I, Phase II, Phase III, or Phase IV cancer clinical trial, approved by 1 of the following:
    -A National Institute of Health (NIH), including a National Institute cooperative group or center,
    -The U.S. Food and Drug Administration,
    -The U.S. Departments of Defense or Veteran's Affairs,
    -A qualified research entity (one meeting NIH grant eligibility criteria), or
    -An expert panel in clinical research at an Arizona academic health institution;
  - Reviewed and approved by an institutional review board of an Arizona institution, to which the health insurer's trade association may appoint a member;
  - Provided by personnel who:
    -Are acting within their scope of practice, experience, training, and expertise; and
    -Agree to accept the insurer's standard reimbursement rates for network providers of similar services.
  - There must be no clearly superior, non-investigational treatment alternative, and available data must offer a reasonable expectation that the treatment in the clinical trial will be at least as efficacious as a non-investigational alternative.

- A health insurer may impose requirements for deductibles, coinsurance, and other similar measures.

- The scientific study must have:
  -A rationale,
  -Background,
  -Specific goals,
  -Criteria for patient selection
  -Directions for administering the therapy and monitoring patients
  -Quantitative measures for determining treatment response, and
  -Methods to document and treat adverse reactions.

- Limitations: No person is liable for damages associated with treatment in a cancer clinical trial, pursuant to the insured's informed consent. This section creates no new liability or cause of action. The Insurance Director enforces the section and imposes an administrative remedy for violations.

Effective date: This bill is effective for policies issued or renewed on or after January 1, 2001.

SB 1294. Mortgage Guaranty Insurance (Ch. 262)

- Amends the definition of "authorized real estate security" in A.R.S. § 20-1541 to raise the permissible loan-to-value ratio for mortgage guaranty insurance from 97% to 100% of fair market value.

- Amends A.R.S. § 20-1550 regarding calculation of a mortgage guaranty insurer's minimum policyholder position.

    - In calculating minimum policyholder position, the face amount of the mortgage must include reinsurance assumed and be calculated net of reinsurance ceded to an authorized or Director-approved reinsurer, but must not be reduced for reinsurance ceded to any captive insurer.

    - Adds language specifying calculation of the minimum policyholder position when a mortgage guaranty insurance policy covers a pool of loans subject to an aggregate loss limit.

    - Adds subsection (H) requiring the insurer to report on its minimum policyholder position with its annual statement.

    - Amends the definition of "face amount of the mortgage" to specify that the amount includes the entire loan indebtedness when minimum policyholder position is calculated under subsection (E) governing coverage on loans secured by second liens.

- Amends A.R.S. § 20-1557 governing reinsurance for mortgage guaranty insurers.

    - Excludes mortgage guaranty insurers from the application of A.R.S. § 20-261(D) requiring prior review and approval of reinsurance agreements.

    - Allows a domestic mortgage guaranty insurer to reinsure with a solvent insurer that has surplus to policyholders less than the minimum capital stock prescribed in A.R.S. § 20-1542 if:
        (A) The Director approves the agreement; or
        (B) The agreement:
            (1) Cedes to a reinsurer that insures or reinsures only mortgage guaranty insurance; and
            (2) Requires ceded reserves to be secured in accordance with A.R.S. § 20-261.02.

    - Requires a mortgage guaranty insurer to provide the Director with annual and quarterly information on its reinsurance agreements, but does not otherwise alter the insurer's obligations to submit reports and obtain approvals. Specifies that the required reinsurance reports are confidential and not subject to disclosure under public records laws. The Director may continue to use the records for regulatory and disciplinary purposes, and the reports are available in civil proceedings, subject to certain requirements.

SB 1330. Healthcare plans; oversight (Ch. 355)

This bill alters the regulatory scheme for oversight of managed health care organizations by transferring responsibilities from Department of Health Services (DHS) to the Department of Insurance. The bill also makes numerous changes in the health care appeals process. Because

this bill amends sections that were amended in other legislation (SB 1032, SB 1435, SB 1173, HB 2043, and HB 2600), various technical changes were included in the bill to ensure conformity with the other legislation. As a result, the bill includes a series of complicated effective dates and should be read together with the other listed bills.

>Regulatory oversight of health care services organizations (HMOs) (unless otherwise noted, changes are effective July 1, 2001.)

- Statutory authority to take the action listed below is transferred from DHS to the Insurance Department, effective July 1, 2001. In most cases, the DHS Director retains the authority to advise the Insurance Director on the exercise of responsibility.
    - Define basic health care services necessary to maintain a person in good health (A.R.S. § 20-1051(1).)
    - Adopt rules setting standards for whether an HMO is "an appropriate mechanism to achieve an effective health care plan" and can provide basic health care services. (A.R.S. § 20-1054(A)(2).)
    - When an HMO applies for a certificate of authority, review and approve its statements describing its organization, health care plans, facilities, personnel and geographic service area. (A.R.S. § 20-1053(A)(5) & (11).)
    - When issuing a certificate of authority to an HMO, determine whether it meets the standards, in rule, for an "appropriate mechanism" able to deliver basic health care services. (A.R.S. § 20-1054(A)(2).)
    - When suspending or revoking an HMO's certificate of authority, determine whether the HMO has failed to provide or arrange for basic health care services. (A.R.S. § 20-1065(A)(3).)

- Amends A.R.S. § 20-1059(A) to repeal the requirement that an HMO file a copy of its annual report with DHS.

- Amends A.R.S. § 20-1064(A) to repeal the DHS Director's authority to conduct an unscheduled examination of an HMO.

- Makes conforming changes in A.R.S. §§ 20-1057(M), 20-1058(D), 20-1059(B)(4), 20-1379(T)(12), and 20-2301(A)(17).

- For fiscal year 2000-2001, appropriates $500,000 and 4 full time equivalent (FTE) positions to the Insurance Department to comply with the new responsibilities. **(Effective immediately, due to Proposition 108 language included in the bill.)**

>Utilization review and health care appeals process (except as noted below, changes are effective March 1, 2001.)

- Amends A.R.S. § 20-2531, **effective immediately**, to exclude the following plans and policies from application of the utilization review requirements and health care appeals process established in A.R.S. Title 20, chapter 15:

    -Multi-employer benefit plans created under 29 U.S.C. § 186(c)[1];

[1] **HB 2591. Health care insurers; utilization review (Ch. 288)** contains an identical amendment excluding multi-employer benefit plans from the application of Title 20, Chapter 15.

-Long term care insurance policies as defined in A.R.S. § 20-1691; and
-Medicare supplement policies, as defined by the Department.

- Amends A.R.S. § 20-2533 to add information that must be included in an insurer's information packet describing the appeals process. The information packet must include:
  -A statement to tell the insured that he or she is not responsible for the costs of an external medical review;
  -Standardized forms prescribed by the Department for pursuing an appeal; and
  -The name and phone number of the Department's consumer assistance unit, with a statement advising that the Department can answer questions about the process.

- Amends A.R.S. §§ 20-2533, 20-2535(B), and 20-2536(B) to revise the times at which the insurer must provide the information packet to an insured. The insurer must still provide the packet at policy inception, and when the insured files an informal appeal.
  -At renewal, the insurer must provide a separate statement regarding the availability of the information packet.
  -The insurer must provide the information packet to the insured or the insured's treating provider on request and within 5 business days of the initiation of an appeal.
  -The insurer's obligation to automatically send an information packet with the acknowledgement of a formal appeal, is repealed.
  -When an insurer issues a denial, the insurer must include a statement of the right to appeal in all explanation of benefits (EOB) documents. If an insurer does not issue an EOB, the insurer must find a reasonable means to advise the insured of the right to appeal. An insurer may satisfy this obligation by requiring the insured's treating provider to notify the insured, using a form statement.

- *Expedited appeals:* Amends A.R.S. § 20-2534 to allow the insurer's utilization review (UR) agent to send an expedited appeal straight to external independent review, without exhausting the insurer's internal process. Also amends A.R.S. § 20-2537 to establish a process for expedited, external independent review ("expedited EIR"). The expedited EIR process mirrors the regular EIR process for medical necessity and coverage issues, but on a faster timetable, as follows:
  -Following a denial under A.R.S. § 20-2534, an insured has 5 business days to file a request for expedited EIR.
  -Upon receipt of insured's request, UR agent has 1 business day to provide the acknowledgement, notice, and other required documentation.

    Medical necessity cases:

    -Upon receipt of all required information from the UR agent, the Department has 2 business days to choose an independent review organization (IRO) and send it the documentation.
    -Upon receipt of all required documentation, the IRO has 5 business days to issue a decision.
    -Upon receipt of the decision, the Department has 1 business day to transmit the decision to the UR agent, the insurer, the insured, and the treating provider.

    Contract coverage cases:

-Upon receipt of all required information from the utilization review agent, the Department has 2 business days to issue a decision and transmit it to the UR agent, the insurer, the insured, and the treating provider.

-The Office of Administrative Hearings must "promptly institute and complete" any expedited appeals.

- *External review:* Amends A.R.S. § 20-2537 governing the external independent review portion of the health care appeals process **(effective August 1, 2000**).

  - Specifies that an insurer must pay only for those services that are covered under the policy when the IRO medical reviewer determines that services are medically necessary.

  -Eliminates general prohibition on using IRO's decision as evidence in other proceedings.

  -Prohibits the IRO medical reviewer, the Director, and the Office of Administrative Hearings from ordering an insurer to pay for services that are excluded under the policy.

- *External independent medical review:* Changes the external review portion of the health care appeals process by giving the Insurance Director the authority to procure independent review organizations (IRO) that can conduct external independent reviews of medical necessity cases. The ability to choose an independent medical reviewer or review organization for a particular case is removed from the insurer and given to the Insurance Director. (A.R.S. § 20-2538 and 20-2537(D).)

  Repeals HB 2600's changes to A.R.S. § 20-2537, governing the external independent review portion of the appeals process, and amends A.R.S. § 20-2537 governing external independent review (EIR) as follows:

  -Requires the UR agent to include the insured's request for review in the materials transmitted to the Department.

  -Requires the UR agent to provide the Department with the name and credentials of the provider who reviewed the appeal at the lower levels, as specified in A.R.S. § 20-2533(G).

  Medical necessity cases:

  -Requires the Department to choose an IRO and send it all required information within 5 days of receipt.

  -Requires the IRO to review the case and issue a decision within 21 days of receiving the required information from the Department. The IRO must base the decision on the total information, but must render a decision that is consistent with the insurer's UR plan.

  -Within 5 days of receiving the IRO's decision, the Department must send the decision to the UR agent, the insurer, the insured, and the treating provider.

  Contract coverage cases:

  -Within 15 business days of receiving all required information, the Director must issue a coverage decision and notify the UR agent, the insurer, the insured, and the treating provider.

  -Broadens the Director's right to send contract coverage cases to the IRO if the case has a medical issue that the Director cannot determine.

-Provides that external independent review decisions are admissible in proceedings involving a health care insurer or UR agent.

- *Independent review organization:* Amends A.R.S. § 20-2538 to require the Insurance Director to procure independent review organizations (IROs)to conduct independent medical reviews. A procured IRO must use appropriately licensed physicians and health care professionals who typically manage the medical condition, procedure, or treatment under review. An IRO and any individual medical reviewer must be disinterested and free of conflicts so as to render a fair and impartial decision. To obtain reimbursement, the IRO must provide the Department with a detailed invoice. (*See* newly enacted A.R.S. § 20-2540.)

- *Health care appeals fund and position:* **(Effective immediately)** Enacts A.R.S. § 20-2540 establishing the health care appeals fund. The fund will include monies assessed and collected from insurers. The Department may assess all health care insurers a one-time assessment of up to $200 to start the fund. The Department will also collect, from insurers, the costs of performing independent reviews. Collected monies will be deposited into the fund, and used to pay the IRO's cost for performing the independent reviews on a per case rate unless the Director determines the need for a different rate. Each insurer will be responsible for paying the costs of its own appeals, as under the current system.

  The Department may also assess health care insurers an annual assessment of up to $200 for the costs of performing the responsibilities related to procurement of the IRO and for implementing and maintaining the external independent review process, including administration of the system for processing and paying for individual case reviews. The Insurance Department is authorized 1 FTE to perform these functions.

- Makes conforming changes in A.R.S. § 20-488.

>**Rulemaking exemption**

- The Department has an 18-month exemption from the Administrative Procedure Act's rulemaking requirements (A.R.S. § 41-1001 et seq.) to adopt rules to implement this legislation. The Department must begin the formal rulemaking process to adopt permanent rules on or before the effective date of the temporary rules. **(Effective immediately.)**

>**Technical corrections and changes to HB 2600**

- Amends A.R.S. § 20-2510, **effective August 1, 2000,** to eliminate references to "indirect denials."

- Repeals A.R.S. § 20-841.08 as added by HB 2600, **effective immediately.**

SB 1454. Voluntary remediation program (Ch. 225)

- Enacts A.R.S. § 49-183 prohibiting denial of insurance coverage solely because an insured is participating in a voluntary remediation program as established under Title 49, Chapter 1, Article 5 or Chapter 2, Article 5. Such programs are designed to correct environmental problems. Section 14 of the bill limits the applicability of A.R.S. § 49-183 to actions filed after the effective date of the bill. (July 18, 2000).

- The bill has an intent clause indicating that the legislation establishing the program is motivated, in part, by "many insurance coverage disputes involving insureds who face potential liability for their ownership of or roles at contaminated sites."

HB 2041. Genetic testing; confidentiality (Ch. 149)

- Enacts A.R.S. § 12-2801 defining "genetic test" or "testing," "authorized representative," and "health care provider." A genetic test is defined as a test of a person's genes, genetic sequence, gene products or chromosomes for abnormalities or deficiencies, under certain listed conditions and with certain listed exclusions.

- Enacts A.R.S. § 12-2802(A) making genetic testing and information derived from testing, confidential. Under subsection (B) the information can be released only to: the tested person; that person's representative who is specifically authorized by law or in writing; and, under certain specified conditions, to researchers, other persons and entities, providers and their agents, employees, and legal representatives, and health officials. Subsection (F) prohibits persons who have obtained release of the information from further disclosure (except to the tested person) unless permitted under this article. Subsection (G) protects health care providers and their agents and employees from liability when acting in good faith, which is a rebuttable presumption.

- Under subsection (C), if genetic testing information is subpoenaed, providers must respond pursuant to A.R.S. § 12-2282. Courts must take appropriate steps to prevent disclosure of any genetic testing information that is obtained.

- Enacts subsections (D) and (E) clarifying the application of other relevant laws:
    - Title 12, Chapter 13, Article 7.1. does not apply to genetic testing information contained in a patient's medical record.
    - A.R.S. § 12-2294(B)(8) governs release of genetic testing information on a deceased person, unless the person made different provisions in a testamentary document.
    - This Article does not limit any Title 20 (Insurance Code) confidentiality protections for genetic testing information.

- Enacts A.R.S. § 12-2803(A) and (B) prohibiting genetic testing on unemancipated minors, without parental/guardian consent, except as allowed under the newborn screening program (A.R.S. § 36-694). The testing physician must notify the parents/guardian of the results.

- Enacts A.R.S. § 12-2803(C) requiring a person's prior consent to perform a genetic test, except as otherwise allowed under A.R.S. § 12-2802(A)(4), (7), or (9).

- Enacts A.R.S. § 12-2804 exempting genetic testing information from disclosure under public records laws, and prohibiting state agencies and local health authorities from releasing the information.

HB 2043 Health insurance; medical foods (Ch. 282)

- Amends A.R.S. § 20-826 (service corporations), 20-934 (benefit insurers), 20-1057 (HMOs), 20-1342 (disability insurers), 20-1402 (group disability insurers) and 20-1404 (blanket disability insurers) and enacts 20-2326 (accountable health plans).

- Parallel provisions in each of the sections listed above require all health insurers that provide prescription drug benefits to cover medical foods used to treat inherited metabolic disorders, subject to limitations set forth in the bill. The metabolic disorders must: (1) be part of the newborn screening program authorized under A.R.S. § 36-694; (2) involve amino acid, carbohydrate, or fat metabolism; (3) have medically standard methods of diagnosis, treatment, and monitoring; and (4) require treatment through specially processed medical foods, typically prescribed by a licensed physician, and needed throughout life to avoid serious physical or mental impairment.

- Health insurers must cover at least 50% of the cost of medical foods, but may limit total annual benefits to $5000. The annual coverage limit is applicable to all prescribed modified low protein foods and metabolic formula.

- The bill defines "inherited metabolic disorder," "metabolic foods," "metabolic formula," and "modified low protein foods."

- Contains a legislative intent clause.

HB 2050 Task force; statewide health care plan (Ch. 320)

- Establishes a task force to comprehensively examine potential solutions to the problem of lack of affordable health insurance coverage for Arizona citizens, and related issues, including:
  - Creation of a statewide health care insurance plan, that will include: a basic health care insurance plan; appropriate benefit levels; affordable premiums; eligibility requirements; accessible enrollment for all Arizona residents, with appropriate safeguards against selective enrollment; and timely reimbursement.
  - Insurance risk pools.
  - The appropriate role of government agencies and political subdivisions.
  - Health care insurance factors that vary among urban and rural areas and equitable treatment of rural and urban areas.
  - Potential funding sources.

- The task force must submit an interim report by December 15, 2000 and a final report by December 15, 2001.

- The task force will include members of the Senate and House of Representatives, a health care provider, a consumer advocate, and a business community member.

HB 2083. Life insurance; dependent coverage (Ch. 91)

- Amends A.R.S. § 20-1257 governing group life insurance. If 75% of the persons who are both eligible for coverage under the group life policy and currently insured under the policy so choose, the insurance coverage (in a fixed amount not subject to individual selection) can be extended to the dependents of an insured person. The amendment raises the ceiling on the coverage limits for dependents to 100% of the insurance on the life of the insured person.

HB 2129. Insurers' unearned premium refund (Ch. 151)

When an insurer is reducing, canceling, or non-renewing an auto insurance policy, A.R.S. § 20-1632 requires the insurer to give the insured a 10-day advance notice of that action, and to refund any unearned premium with the notice. A longer refund period is allowed if the insured finances the premium payments.

- Amends A.R.S. § 20-1632(A)(3). When the insurer receives premiums from its affiliated company that bills and collects premiums on the insurer's behalf (i.e. similar to a finance company), the insurer must refund any unearned premium within 10 days of the advance notice of action. "Affiliated company" has the same meaning as prescribed in A.R.S. § 20-481.

HB2181. Senior residential entrance fee contracts (Ch. 206)

- Amends A.R.S. § 44-6951 to add definitions for "audited financial report" (a financial statement prepared by an independent CPA) and the Department of Insurance and the Insurance Director.

- Renumbers A.R.S. § 44-6952 as A.R.S. § 44-6954.

- Enacts A.R.S. § 44-6952 requiring providers to register with the Insurance Department on a Department form that includes identifying information (name, addresses, phone numbers) on the provider and its principals, it's chief financial officer, its multiple facilities, and its fiscal year end date. When filing the form, the provider must also submit its disclosure statement required by A.R.S. § 44-6954(D)(2), its most recent audited financial report, and a registration fee. *(On and after June 19th, the registration form will be available on the Department's web site, under "Forms," and from the Corporate and Financial Affairs Division at 602/912-8420.)*

- Enacts A.R.S. § 44-6953 governing maintenance of registration. Under subsection (A), within 180 days of its fiscal year end, a provider must file its annual financial report for the ended fiscal year. If a provider fails to timely file the report, the Department must give the provider 30 days written notice to file. If the provider fails to file within 30 days of that notice, the Department must cancel the provider's registration, and notify the provider and the consumer fraud section of the Attorney General's office. Under subsection (C), the Department must also give such notice if the provider's financial statement has a qualified opinion or an expression of doubt about the provider's ability to continue as a going concern.

- Enacts A.R.S. § 44-6953(B) requiring the provider to notify the Department of any changes to its disclosure statement within 14 days of the change. The Department must notify the provider and the consumer fraud section of the Attorney General's office if the provider uses a disclosure statement that has not been filed with the Department.

- Amends A.R.S. § 44-6954 with conforming changes about the obligation to register with the Insurance Department. Extends certain protections to the "application agreement" which may be signed before the entrance fee contract. Amends the requirements regarding disclosure statements, which must be: written in plain English and no longer than 2 pages; and include a statement advising persons with complaints to contact the Insurance Department or the consumer fraud section of the Attorney General's office.

HB 2251. Health benefits plans (Ch. 188)

- Amends A.R.S. § 20-2302 by deleting a reference to Internal Revenue Code (IRC) § 125. The deleted language means that Arizona's accountable health plan law does not automatically apply to a health benefits plan that the employer treats as part of a plan under IRC § 125. New language clarifies that the accountable health plan law applies to any health benefits plan that qualifies as group health plan under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) § 2791(a)(1).

HB 2600. Managed Care Accountability Act (Ch. 37)

Guide to terms used in this summary

Various terms are used throughout the Act. Unless otherwise specified, the following terms have the following general meanings in this summary:

> "Insured" means an individual who is covered under a health insurance policy, and includes enrollees, members, subscribers, covered persons.
>
> "Professional" or "Health care professional" is formally defined in A.R.S. § 20-3151(4) to include individual health care practitioners certified or licensed under Titles 32 & 36 in the following areas: physical and mental health, dental health, and optometric health. (Omitted from list: professional counselors; occupational therapists; respiratory therapists; acupuncturists, audiologists, and speech-language pathologists.)
>
> "Health insurer" means a disability insurer, a hospital or medical service corporation, and a health care services organization (HMO).
>
> "Provider" means health professionals and hospitals.

Anti-retaliation provisions

- Parallel amendments in A.R.S. §§ 20-118 (general provisions); 20-827(B)(2) (service corporations); 20-934(A)(12) (benefit insurers); 20-1061(B)(2) (HMOs).

- Adds provisions prohibiting retaliation against health professionals. An entity regulated under Title 20 cannot terminate or non-renew a health care professional's contract solely because the professional:
  -Advocates for a patient;
  -Helps a patient get reconsideration of a denied health care service; or
  -Reports a legal violation to an appropriate authority.

  Contract means a written agreement to provide specified health care services to covered persons, but does not include a salaried, employment contract.

Third party intermediaries (TPI)

Enacts A.R.S. § 20-120 regarding payment bonds or deposits for third party intermediaries, which are defined as an entity that assumes business risk through a written contract with a health insurer to provide covered benefits to covered persons if the TPI or its subcontracting professionals cannot provide the services.

- *Payment bonds:* Prohibits a health insurer from contracting with a TPI to provide health services to the insurer's insureds unless the TPI has a payment bond or posts a cash deposit that satisfies the requirements listed below.
  - The bond/deposit must equal or exceed 2 times the average monthly payment amount from the insurer to the TPI.
  - The bond must be executed by a surety company authorized to do business in Arizona or the cash deposited with the State Treasurer.
  - The bond/deposit must be used solely for payment of claims for covered health services that subcontracted health care professionals have provided to insureds covered by the contract between the TPI and the health insurer, and cannot be used to satisfy other creditors. A TPI is allowed to make the deposit over a 6-month period by the insurer withholding 1/6 of each monthly contractual payment to the TPI, and depositing that amount with the State Treasurer.
  - A professional who has not been paid for covered services within 90 days of the last service date may sue on the bond/deposit to collect unpaid amounts.
  - An insurer who pays subcontracted professionals when its TPI fails to do so may also sue on the bond/deposit to recover for the claims paid.
  - Any suit on the bond must be brought within 1 year after the last service date (professionals) or last claims payment date (insurers). Any suit on the deposit must be brought within 1 year of the last service date (professionals) or at least one year after the last claims payment date (insurers). The prevailing party may recover reasonable attorneys fees.
  - The insurer must annually review the amount of the bond/deposit to determine required adjustments.

- *TPI-Insurer Contractual Arrangements:* Any contractual agreements between a TPI and an insurer must include the following provisions:
  - The TPI must quarterly report to the insurer on the timeliness of all payments to subcontracted professionals
  - The TPI must pay subcontracted professionals according to the "timely pay" requirements in A.R.S. § 20-3102.

- *TPI- Timely Pay:* Subsection (I) requires a TPI to approve or deny claims as required under A.R.S. Title 20, Chapter 20 (discussed below).

- *Limitations:* Subsection (E) clarifies that the new TPI law does not:
    - Allow for the unlicensed transaction of insurance.
    - Require a TPI to post a bond/deposit if the TPI holds a certificate of authority as a health insurer.
    - Create any new right of action, other than to sue on the bond/deposit.
    - Require a TPI that serves as a provider network for an affiliated staff or group model HMO, under common ownership or control, to post a bond/deposit under this section. The HMO may still require some form of bond/deposit. If it fails to do so, and the TPI fails to pay subcontracted professionals, the HMO is required to pay under the subcontracts.
    - Require a professional to post a bond/deposit if the professional has only assumed the business risk of providing services within his or her lawful scope of practice.
    - Limit the health insurer's ability to impose other financial requirements on a TPI.

- *Release, reduction, & termination of bond/deposit:* Under subsection (F), the TPI's bond/deposit may be released when the TPI extinguishes its liability to the insurer, through reinsurance, or otherwise, or upon court order to a person who succeeds to management and control upon the TPI's bankruptcy or insolvency (i.e. a receiver or trustee). The TPI can also obtain a release of any amounts above the statutorily prescribed level (two times one month's average payment.) Under subsection (G), a surety must give the Director 30 days notice before terminating a bond issued under this section. Upon application, the Director may order the release of deposits. (Subsection (H).)

- *Delayed effective date:* This section applies to TPI – Insurer contracts entered into after December 31, 2000. (Subsection (J).)

- Amends A.R.S. § 20-485 to specify that it does not apply to a person acting solely as a TPI under A.R.S. § 20-120.

"Off-label use" of prescription drugs

- Parallel amendments in A.R.S. §§ 20-826(R) & (S) (service corporations); 20-934(N) & (O) (benefit insurers); 20-1057(V) & (W) (HMOs); 20-1342 (F) & (G) (disability insurers); 20-1402 (F) & (G) (group disability insurers); and 20-1404(O) & (P) (blanket disability insurers) and enactment of A.R.S. § 20-2326 (accountable health plans). Conforming changes (regarding health insurers' disclosure statements) in A.R.S. § 20-2323(A)(5) (accountable health plans).

- A health insurer that covers prescription drugs cannot limit coverage of a prescribed cancer treatment drug, or the medically necessary services associated with administration of that drug, merely because the drug is not FDA-approved to treat the insured's specific cancer, if the drug is recognized as safe and effective for treatment of the specific cancer in at least 1 standard medical reference compendia or medical literature. The statute lists acceptable compendia and literature.

- An insurer is not required to cover:
  - A drug that the FDA has determined is contraindicated for the insured's specific type of cancer.
  - Any experimental drug that is not FDA approved for any indication.
  - Any drug that is not included on the insurer's formulary or in a list of covered drugs prescribed in the insured's contract.

- This section does not change any other laws limiting coverage of non-FDA-approved drugs.

Advertising review

- Parallel and conforming amendments in A.R.S. §§ 20-826(T) (service corporations); 20-1007 (prepaid dental plan organizations); 20-1057 (HMOs); 20-1110 (E) (life and disability insurers). Conforming repeal and enactment of A.R.S. § 20-1018 (prepaid dental plan organizations).

- Eliminates Department's prior review and approval of life and health insurers' advertising and sales materials.

- Insurers must continue to file the materials with the Department before using them.

- If the Director determines that the materials are false, deceptive, or misleading, the Director may issue an order disapproving the materials, imposing penalties, and directing the insurer to stop using the materials, within a specific time period that cannot be less than 10 days.

- At least 5 days before issuing a disapproval order, the Director must give the health insurer written notice of the basis for the order, and a single opportunity to cure within that 5 day period.

- The Director's order is appealable under the Uniform Administrative Appeals Act. (A.R.S. § 41-1092 *et seq.*) An insurer may stay the effectiveness of the order until after an administrative hearing and decision by filing a notice of appeal within 10 days of the order, as provided in A.R.S. § 20-162. If the Director makes an express finding that immediate, summary disapproval is required for protection of public health, safety, or welfare, the Director is not required to give the 5-day cure period, and the insurer cannot stay the effectiveness of the order.

Prohibited financial incentives

- Parallel amendments in A.R.S. §§ 20-833(D) (service corporations); 20-934(P) (benefit insurers); 20-1061(C) (HMOs).

- Adds language prohibiting a health insurer and a health professional from entering into a contract that specifically pays, or withholds payment from, the professional to induce him/her to deny, reduce, limit, or delay medically necessary care covered by the insurer. The new subsection has a safe harbor provision for per diem or per case payments, diagnostic related

grouping payments, and financial incentive plans that are unrelated to specific medical decisions, such as capitation payments and shared risk arrangements.

- Insurers must annually file a written certification of compliance with this requirement.

Standing referrals

- Parallel enactments in A.R.S. §§ 20-841.04 (service corporations); 20-936.01 (benefit insurers); and 20-1057.01 (HMOs). (Does not apply to insurers providing only dental and optometric coverage.)

- Enacts new law requiring health insurers to have a procedure for an insured to get a standing referral to a network specialist when:
  - The insured has a disease or condition that is life-threatening, degenerative, chronic, or disabling, and the insured's primary care physician ("PCP") believes that the insured will need ongoing medical care for an extended period of time, to treat the condition/disease.
  - The insured's PCP and a network specialist decide that the insured needs the specialist's expertise.
  - The PCP refers the insured to the specialist, who must provide and coordinate the insured's specialty care.
  - The insurer authorizes the specialist to care for the insured under the standing referral.

- A "network specialist" is a health professional who has contracted with the insurer to provide services in a specialty discipline recognized by an American Medical Specialty Board.

- An insurer's procedures for a standing referral:
  - May limit the number of visits and time period for the referral.
  - Must continue the referral to the network specialist even if the PCP leaves the network and the insured obtains a new PCP.
  - May terminate the standing referral if the specialist leaves the network, or the insurer no longer covers the insured.

Prescription drugs and formularies

- Parallel amendments in A.R.S. §§ 20-841.05 (service corporations); 20-936.02 (benefit insurers); 20-1057.02 (HMOs). Conforming changes (regarding health insurers' disclosure statements) in A.R.S. § 20-1076(A)(5) (HMOs). Does not apply to insurers offering only dental or optometric coverage.

- An insurer that covers prescription drugs and uses a drug formulary must notify its insureds about the formulary and have a formulary process. ("Prescription drug" means a prescription medication as defined in A.R.S. § 32-1901, that a health professional prescribes to treat an insured's condition.)

- *Notice:* The notice must be in simple terms and explain what a drug formulary is, how the insurer to decides to add and remove drugs from the formulary, and how often the insurer reviews the formulary for changes.

- *Process:* The formulary process must:
  - Allow health professionals to get authorization for medically necessary drugs (on and off the formulary) during nonbusiness hours. An insurer that does not maintain such a process must reimburse the insured for the insured's out-of-pocket expenses (minus copayments and deductibles) for drugs that the insured bought without preauthorization, but which the insurer later approved.

  - Allow health professionals to obtain authorization for medically necessary, non-formulary prescription drugs (if the insured's plan requires the insurer's authorization). The insurer must authorize such drugs when:
    - The equivalent alternative on the formulary has been ineffective in treating the insured's condition; or
    - The insured has had an adverse or harmful reaction to the formulary alternative.

- If an insurer refuses to authorize a non-formulary drug after the insured's treating health professional finds that the insured meets one of the above conditions, the insurer must send the insured and the treating provider a written denial that is signed by a licensed pharmacist or Medical Director, and that explains the insurer's reasons.
  The insurer must keep all such records available for regulatory inspection.

- *Notice and coverage of removed drugs:* When an insurer removes a drug from its formulary, the insurer must send written notice to each of its non-affiliated, contract pharmacies. The pharmacy must then notify the insured of the removal when the pharmacy is dispensing a prescription for the removed drug. The pharmacy can give notice to the insured through a verbal consultation or direct communication, and must advise the insured to consult a health professional to get a different prescription before the end of the 60-day coverage window described below.

- For 60 days after the insurer notifies the pharmacy, or the pharmacy notifies the insured (whichever first occurs) the insurer must cover the removed drug if:
  - The drug was on the formulary when prescribed, was approved to treat the insured's condition, and the insured's treating provider continues to prescribe the removed drug for the same medical condition; and
  - The drug is appropriately prescribed and deemed safe and effective for the insured's medical condition.

- *Exclusions and limitations:* The formulary section does not:
  - Apply to insurers offering a multitiered benefit plan that permits access to all prescription drugs, without insurer authorization.
  - Limit an insurer's ability to apply deductibles, coinsurance, or other cost-containment or quality assurance measures.

Continuity of care

- Parallel enactments in A.R.S. §§ 20-841.06 (service corporations); 20-936.04 (benefit insurers); 20-1057.04 (HMOs). Conforming changes (requiring health insurers to describe their continuity of care policies in their disclosure statements) in A.R.S. § 20-1076(A)(7) (HMOs). Does not apply to an insurer providing only dental or optometric coverage.

- An insurer must allow a newly enrolled insured to continue an active course of treatment with his/her treating provider (i.e. an Arizona licensed doctor of medicine or osteopathy) who is not a member of the insurer's contracted provider network, as follows:
  - If the insured has a life threatening condition, the transition period is 30 days after the effective date of coverage.
  - If the insured is in the 3rd trimester of pregnancy on the effective date of coverage, the transition period is through 6 weeks after delivery, for care related to the delivery.
- Transitional coverage is not allowed unless the insured's treating provider agrees in writing to:
  - Accept the insurer's normal reimbursement rates for similar services;
  - Comply with the insurer's quality assurance and utilization review requirements;
  - Provide the insurer with medical information related to treatment of the insured; and
  - Comply with the insurer's policies and procedures related to referrals, pre-authorization, claims handling, and treatment plan approval.

- If an insurer terminates a provider from its network for reasons other than medical incompetence or unprofessional conduct, the insurer must extend the same transitional care rights to allow a current insured to continue an active course of treatment with his/her provider, subject to the same conditions and limitations described above. The transition period runs from the date of the provider's network disaffiliation.

- This section does not:
  - Require an insurer to cover benefits not otherwise included in the insured's policy.
  - Impair any policy limitations on coverage of pre-existing conditions.
  - Give a non-network health provider any contractual rights or remedies beyond those related to providing the transitional care.

Medical supplies

- Parallel enactments in A.R.S. §§ 20-841.07(service corporations); 20-936.05 (benefit insurers); and 20-1057.05 (HMOs).

- An insurer that covers medical supplies must have participating medical vendors who are reasonably available to its insureds. The Insurance Department will determine reasonable availability, and will consider hours of service and areas of coverage within the insurer's geographic service area.

Provider discrimination

Enacts A.R.S. § 20-841.08 prohibiting a service corporation from provider discrimination regarding reimbursement procedures. **NOTE: This new section was repealed in Laws 2000, Ch. 355, sec. 23, effective immediately. (See SB 1330, p. 51.)**

Chiropractic care

Parallel enactments in A.R.S. §§ 20-936.03 (benefit insurers); 20-1057.03 (HMOs).

- Requires benefit insurers and HMOs to provide certain coverage of chiropractic care, as a mandated benefit, subject to the following limitations:
  - The health insurer may limit covered benefits to services provided by a network chiropractor.
  - An insured may self-refer to a network chiropractor for at least 12 annual, medically necessary visits, or such greater number as allowed under the insured's policy. An insured may have more visits with any chiropractor if the insured accepts financial responsibility for payment.
  - This section does not require the insurer to provide services that are not covered under the insured's policy, and does not lessen any preexisting condition limitation in the policy.
  - The insurer may continue to use deductibles, coinsurance, copayments, and other cost sharing measures for chiropractic benefits.

- By January 1st, benefit insurers and HMOs must annually report to the Insurance Director on chiropractors in the insurer's contract network, including total number, names, and addresses. This reporting requirement is repealed June 30, 2004.

HMO – Cancellation/Non-Renewal of coverage

- Amends A.R.S. § 20-1057(H) and (N) governing cancellation and non-renewal of group and individual policies, to clarify the HMO's obligations to individual enrollees under a group policy.

- The HMO must notify individual enrollees when canceling or non-renewing the enrollee's evidence of coverage issued on a group basis.

- An HMO cannot cancel an enrollee's evidence of coverage issued on a group basis, simply because of the age of the enrollee's dependents.

- The evidence of coverage must specify the reasons why the HMO may cancel/non-renew an evidence of coverage for the enrollee or a dependent.

- Affirms the right of an HMO to cancel a group policy for the reasons listed in A.R.S. § 20-2309 (renewability for accountable health plans.)

HMO - Prior authorization

- Enacts A.R.S. § 20-1057.06 which prohibits an HMO from asking a health professional for information unrelated to the medical condition at issue, for the purpose of determining whether to authorize a request for services.

HMO - Balance billing

Under current law, an HMO enrollee is not liable to a network health professional (contract provider)for any amounts that the HMO may owe the provider. Network providers cannot balance bill HMO enrollees for covered services, except for normal copayments and coinsurance. The prohibition extends both to amounts unpaid under the contract and to those representing the difference between the provider's normal rate and the contract rate.

- Amends A.R.S. § 20-1072. Extends the prohibition on balance billing, to network hospitals. If a provider or hospital copies an enrollee on billing statements to the HMO or sends the enrollee any other billing information directed to the HMO, the information must prominently display specific language indicating that it is not for payment and is informational only.

- Enacts new subsection (I) requiring the Insurance Director to penalize any provider or hospital for violations of this provision. The penalty must be three times the amount of the charges.

- Enacts new subsection (J) expressly stating the Director's obligation to investigate complaints and enforce this section.

Medical directors

- Amends A.R.S. § 20-2510 by enacting a new subsection (B) to require that a health insurer's medical director sign an explanatory statement when denying prior authorization of a requested service on the basis of medical necessity. Except as specified below, the medical director must be an M.D. or a D.O. with an active, unrestricted license to practice medicine in Arizona, and is specifically made responsible for the signed denial. The insurer must send a copy of the denial statement to the provider who sought authorization and keep a copy available for Insurance Department inspection.

- An insurer providing only dental services may use an Arizona licensed dentist (Title 32, Ch. 11) as its medical director. An insurer providing only optometric services may use an Arizona licensed optometrist (Title 32, Ch. 16) as its medical director.

NOTE: Laws 2000, Ch. 355, sec. 12 further amended this section, effective August 1, 2000, to eliminate the requirement that indirect denials be in writing. (See SB 1330, pp. 32-33)

Expedited appeals

The bill amends A.R.S. §§ 20-2533, 20-2534, 20-2536, and 20-2537. These amendments conform to amendments in SB 1330, establishing an expedited appeals process. To the extent that any changes are non-conforming, SB 1330 prevails. (See discussion above under SB 1330.)

Provider grievances: contractual disputes and timely payment of claims

Enacts new Chapter 20 (A.R.S. §§ 20-3101 & 20-3102) specifying requirements governing the relationship between health insurers and providers (health professionals and hospitals, but excluding salaried employees), and also requiring insurers to timely pay provider' claims.

- *Grievance process:* A health insurer must have a grievance system to resolve provider disputes over payment and other contractual issues. The Insurance Director may review the system. The insurer must keep records of its provider grievances, and send the Director a semi-annual summary of those grievances. The records must identify the provider, describe the nature of the grievance, and list dates of filing and resolution. The Insurance Director may examine an insurer with a significant number of unresolved grievances.

- *Payment of claims:* Upon receipt of a claim, a health insurer must:
  - For incomplete claims, send a written request for any additional information needed to act on the claim, within 30 days of receipt; or
  - For clean claims (those needing no more information from the provider or a third party), approve or deny the claim within 30 days of receipt or the time period specified in the provider's contract with the insurer ("contract period").

  - The health insurer must pay approved clean claims within 30 days of approval or the contract period.

  - For incomplete claims, any request for more information must include all reasons for the delay in acting on the claim. Any request cannot seek information unrelated to the medical condition at issue. The insurer must approve or deny the claim within 30 days of receiving the additional information, and pay approved claims within the same 30 days or the contract period.

  - A health insurer must pay the legal rate of interest on unpaid claims from the payment due date.

  - Without reasonable justification, a health insurer cannot: delay payment of clean claims; reduce the amount of contractual payments; or request resubmission of claims information (that the provider can document was already provided). Except in cases of fraud, neither an insurer nor a provider can request adjustment of a claim payment more than 1 year after payment.

- *Limitations:* This section does not require or allow the Insurance Director to adjudicate individual disputes between health insurers and providers.

Health care insurer liability

Enacts new Chapter 21 (A.R.S. §§ 20-3151 - 20-3155) imposing liability on insurers for certain conduct.

- *Liability:* A health insurer is liable for an enrollee's damages caused by the insurer's:
  - Delay in authorizing, or refusal to authorize, a request for medically necessary health care services covered under the insured's policy; or
  - Denial of payment for covered benefits,

  If both of the following are true:
  - The insurer had "no reasonable basis" for the delay, refusal, or denial; and

- The insurer knowingly acted without a reasonable basis, or failed to take adequate steps to determine whether there was a reasonable basis for the action.

An insurer is not liable for inadvertent or unintentional conduct.

- *Notice of claim:* Before suing an insurer under this Chapter, the enrollee must either complete a health care appeal under A.R.S. § 20-2530 et seq., or give the insurer at least 30 days notice of intent to sue and the basis of the suit. The method of notice is specified. Pursuit of a health care appeal does not limit an enrollee's right to sue under this chapter after the appeal is finished.

- *Evidence:* Evidence and information derived from a health care appeal, and an enrollee's decision not to pursue a health care appeal, is admissible in an action under this chapter.

- *Limitations:* This chapter does not:
  - Impose liability on an employer who buys or self-funds insurance for its employees.
  - Impose any new or additional liability on health insurers for the medical negligence of a treating provider.
  - Alter any other theory of liability or defense

- *Exclusive remedies:* A lawsuit under this chapter and a lawsuit for breach of the common-law duty of good faith and fair dealing, are mutually exclusive remedies. An enrollee who sues for one cannot sue for the other.

- Any waiver of this chapter is unenforceable.

Application of other laws

Amends A.R.S. §§ 20-821 (service corporations), 20-923 (benefit insurers), 20-1068 (HMOs) to specify that Chapters 20 and 21, the new chapters of the Insurance Code added by this bill, will apply to such insurers.

Effective Date

This bill applies to contracts, policies, and evidences of coverage issued or renewed on and after January 1, 2001. The Department interprets this section as delaying the effective date of all provisions until January 1, 2001.

Re SB 1069: Form to certify status as an industrial insured.

To: _____
(Complete Name Of Insurer)

I, _____ (your name) certify that:

1. I am _____ (owner or an officer) of _____ (name of industrial insured as it will appear on the insurance policy to be issued by the above-named insurer**)**.

2. I have read and understand A.R.S. § 20-401.07(A)(1) set forth below;

"Industrial insured" means an insured that meets at least two of the following criteria:

☐ a. Applies for or procures any insurance that is subject to Article 4.1 of this chapter through the use of a risk manager.

☐ b. Has aggregate annual gross premiums for insurance on all property and casualty risks that are subject to Article 4.1 of this chapter totaling at least five hundred thousand dollars as of the preceding fiscal year end of the industrial insured.

☐ c. Possesses a net worth of over fifty million dollars as of the preceding fiscal year end of the industrial insured as verified by a certified public account.

☐ d. Has net revenues or sales exceeding one hundred million dollars as of the preceding fiscal year end of the industrial insured as verified by a certified public accountant.

☐ e. Has more than five hundred full-time employees or equivalent per individual company or one thousand full-time employees or equivalent per holding company system as of the date the policy is issued.

3. _____ (name of industrial insured) is an industrial insured pursuant to A.R.S. § 20-401.07 and meets the statutory criteria checked above (check all that apply in number two).

CERTIFICATION

STATE OF: _____)

COUNTY OF:_____)

Being first duly sworn, _____deposes and says that he/she has read the foregoing, and each statement and answer made, and under penalty of perjury, swears that all such answers are true and correct.

_____
Full **Signature** of Officer or Owner
(*Include FULL first, middle and last names*)

SUBSCRIBED AND SWORN TO before me this _____ day of _____, _____.

_____
Notary Public (SEAL)